

HSCRC Transformation Implementation Program Request for Proposal

August 28, 2015

The Health Services Cost Review Commission (HSCRC) seeks proposals for supporting the implementation of plans to improve care coordination and population health in support of Maryland's All-Payer Model.

In 2014, the State of Maryland and the Center for Medicare & Medicaid Innovation (CMMI) reached an agreement to modernize Maryland's all-payer rate-setting system for hospital services. This initiative allowed Maryland to adopt new and innovative policies aimed at improving care, improving population health, and moderating the growth in hospital costs. Transforming Maryland's health care system to be highly reliable, highly efficient, and a point of pride in our communities requires increased collaboration among health systems, payers, community hospitals, ambulatory physician practices, long-term care, and other providers, as well as patients and families, public health, and community-based organizations.

Background

The State of Maryland is leading a transformative effort to improve care and lower the growth in health care spending through Maryland's All-Payer Model. Effective January 1, 2014, Maryland and CMMI entered into an agreement to modernize Maryland's unique rate-setting system for hospital services. This initiative aims to enhance patient care, improve population health, and lower total costs. HSCRC and DHMH envision a health care system in which multi-disciplinary teams including physicians and nurses, as well as individuals outside the medical model such as nutritionists, social workers, public health practitioners, and community health workers, and faith leaders work with high-need/high-resource patients and their families to manage chronic conditions and address functional limitations and socioeconomic determinants of health. The All-Payer Model operates in conjunction with a number of other endeavors currently underway in Maryland, including efforts to strengthen primary care and coordinate hospital care with community care; map and track preventable disease and health costs; develop public-private coalitions for improved health outcomes; and establish Regional Partnerships.

While changes to hospital payment mechanisms consistent with the All-Payer Model are well underway, continued work and investments are needed to integrate and support the efforts of health systems, payers, community hospitals, independent ambulatory physicians, community providers, public health, and others to improve care delivery for patients. In accordance with the Budget Reconciliation and Financing Act (BRFA) of 2014, the Commission increased rates

on May 1, 2015 to provide up to \$15 million for the purpose of funding the planning of regional partnerships throughout the State along with statewide infrastructure to support care management, coordination, and planning. During its June 2015 public meeting (see below), the Commission approved additional increases for all global budgets. Global Budget Revenue (“GBR”) hospitals will receive an increase of 0.40% for infrastructure investments in FY 2016. DHMH and HSCRC are announcing an additional funding opportunity to improve care coordination and population health. The funds are intended to supplement related existing infrastructure initiatives. **Competitive transformation implementation awards** will be available to any Maryland acute care or specialty hospital (including TPR hospitals) that submits a successful bid. The aggregate amount available for these awards is up to 0.25% of statewide revenue, although no hospital may receive more than 0.75% of the hospital’s FY 2015 net patient revenue plus markup.

The **competitive transformation implementation awards** are intended to support and leverage a culmination of investments and activities related to partnerships, strategies, progress, and vision for care coordination and provider alignment in the State (See Appendix D for summary of care coordination investment and Timeline of related activities). The intent of these partnerships and strategies is to reduce potentially avoidable utilization at Maryland hospitals through better care coordination and provider alignment that results in improvement on the metrics required under the new All-Payer Model. Those metrics include:

- Keeping the all-payer total hospital per capita revenue growth rate for Maryland residents below 3.58%;
- Achieving Medicare savings for Maryland beneficiaries in the amount of \$330 million over 5 years compared to Medicare trend;
- Bringing the Maryland Medicare readmission rate to below the national average;
- Reducing Maryland Hospital Acquired Conditions in the State by 30% over 5 years; and
- Keeping Maryland Medicare per beneficiary growth over any two-year period at or below the national growth.

Awards are meant to build upon GBR infrastructure increases received in FY 2014 and FY 2015 and those plans being developed for the Regional Partnerships.

Hospitals interested in applying will be required to submit proposals describing how they will use these additional funds to work in collaboration with other hospitals, physicians, post-acute providers and other community based providers as well as patient and family advisory groups and organizations to improve care coordination and population health. Successful applicants will have care coordination and population health models underway and require additional infrastructure support to bolster immediate implementation of projects in the final stage of planning that will result in a positive return on investment, particularly through an early

emphasis on high utilizers. The collective goal of these activities is to help support delivery system change with a focus on:

- Supportive services for persons living with chronic disease
- Long-term care and post-acute care integration and coordination
- Integration and coordination of physical and behavioral health services
- Support of primary care, particularly so that care plans and most medical services are well coordinated
- Identification, case management, and other supports for high needs and complex patients
- Episode improvements, including quality and efficiency improvements
- Patient-centered clinical consolidation and modernization to improve quality and efficiency
- Consumer and community engagement strategies aimed at improving patient and family-centered care and communication.
- Integration of community resources relative to social determinants of health and activities of daily living

Competitive transformation implementation awards are intended as an add-on to approved hospital rates. If awarded, enhanced GBR reporting will be expected. Activities will be monitored and measured to demonstrate how funds have been used to improve performance and show the impact that the related programs and interventions have on core outcomes.

Appendix A represents a sample of the type of metrics that may be required for reporting. Final reporting requirements will be issued following the award process.

Application Requirements and Timeline

Applications must be single-spaced, single sided, Calibri style and 11 point font size and submitted by the date below to hscrc.rfp-implement@maryland.gov. A review committee appointed by the HSCRC will review the applications. Funding guidelines and selection criteria, listed on page 4 and pages 8-10, respectively, will be used by the committee to recommend funding decisions.

- Funding announcement: August 28, 2015
- Bidders' Conference TBD (September) Time, Location
- Application deadline: December 7, 2015, 11:59 pm
- Anticipated award announcement: January 2015

Sections 1-6 and 8-9 of the Narrative must be submitted in Word or similar formats.

Section 7 of the Narrative (Implementation Work Plan) must be submitted in a PDF of Microsoft Excel or a common project management software, such as Microsoft project.

Contact Information

During the application process, questions and answers will be posted on the HSCRC website. Additional questions may be submitted to:

Steve Ports
Director, Center for Engagement and Alignment
Maryland Health Services Cost Review Commission
Phone: (410) 764-2591
Email: hscrc.rfp-implement@maryland.gov

Eligibility Criteria

Applications for a competitive transformation implementation award may be submitted by:

- An individual hospital
- Multiple hospitals as lead applicants
- A hospital participant from a regional partnership as a lead applicant applying on behalf of a regional partnership

All applications **must** include (in addition to the lead hospital or hospitals) collaborating providers, physicians, or other community based organizations. Applications that include a broad and meaningful network, including patient and consumer representatives, will receive additional points when scored.

A hospital may participate in multiple applications as a single entity and as part of a Regional Partnership or another collaboration. Each application will need to demonstrate how plans and resources complement one another. Applications must be able to describe how they are distinct from one another and, if there is overlap, identify where overlaps exist and where there is distinction with respect to return on investment (ROI) and the budget.

There is no limit to the number of applications any one hospital may participate in. However, the total dollars awarded to a hospital acting as a single entity are capped at 0.5% of the hospital's FY 2015 net patient revenue plus markup. Total combined awards to a hospital through single entity applications, regional partnership applications, and multiple hospital applications are capped at 0.75% of the individual hospital's FY 2015 net patient revenue plus markup.

The State reserves the right to make awards based on applications received and will determine how funds are dispersed. This means that:

- Determinations by the review committee and HSCRC are final and not subject to appeal;
- The HSCRC may suggest alterations to the scope or amount of a proposal during the process;
- The HSCRC may require an applicant to alter a proposal or proposals to come into compliance with the award limitation described above.

Funding and Budget Guidelines

Consistent with existing law, applications will be required to clarify how funds will be distributed and flow to collaborating hospitals, providers, physicians or Community-based Organizations (CBOs). If more than one hospital applies as a lead applicant, the application and budget must clarify if:

1. Each of the lead hospitals will receive an increase in rates to generate the funds to be shared in accordance with a proposal; or
2. One of the collaborating hospitals will receive an increase in rates to be shared with the other collaborating hospitals.

Awarded funds will be collected by the hospital through rate increases in Rate Year 2016. It is expected that Rate Year 2016 awards will be expended within CY 2016.

Applicants will be expected to calculate the annual Return on Investment (ROI) for the funds. The HSCRC expects that a portion of the ROI accrue to payers. Applicants are expected to show how the ROI will be apportioned between the hospital(s), and payers and how the payer portion will be applied (global budget reduction, etc.). Applicants are also expected to demonstrate how the program/intervention is helping Maryland meet the goals and requirements of the All-Payer Model agreement with CMMI. Given that these awards are intended to build on and leverage previous infrastructure investments, the ROI should include the incremental impact of this particular funding with all investments made in mind. The ROI is intended to sustain successful programs into the future by encouraging continued alignment between hospitals and other providers. While award dollars may not be used for provider incentive programs (such as pay-for-performance), ROI may be utilized to support such programs, provided of course, that they are permissible under State and Federal Law.

The proposed budget is expected to demonstrate the applicant's ability to execute the intervention, to the extent practicable, within CY 2016. In addition, the budget should clearly detail how funds will flow to all partners included in the application.

Narrative Requirements

The narrative describes your project. It consists of sections 1-6 and may not be longer than 20 pages.

1. Target Population

This section must define the geographic scope of the model via a comprehensive list of the ZIP codes included, as well as counties and incorporated cities. Additionally, data and a corresponding narrative should be used to describe the health need(s) and condition(s) that the delivery model will address within the proposed geographic area. Applicants are required to utilize existing Community Health Needs Assessments (CHNAs) or other related documents to describe the health need.

2. Proposed Program or Intervention(s)

This section must include a description of the proposed delivery/financing model(s) to be implemented or enhanced. The description should include information on the target patient population(s), the services and/or interventions the patients will receive, and the role of each participating partner in the program or intervention. This section should also describe the infrastructure (e.g., analytics) and workforce that are needed to support the model. The discussion of the proposed program or intervention should be very specific and describe how programs, interventions, and resources, complement other programs/interventions underway based on previous infrastructure investments being pursued by an individual hospital as part of a Regional Partnership or other collaboration. Also, include a description of how they are distinct from one another and, if there is overlap, clarify how they intersect.

While the program/intervention itself should focus on particular patient populations, such as patients with multiple chronic conditions and high resource use, the proposal should describe how the program/intervention will improve population health. The proposal should also describe how the model of intervention fits within your overall hospital strategic transformation plan.

3. Measurement and Outcome

This section should describe how progress on the program, model or intervention be measured. The section should describe the expected outcomes and include baseline data and measures. Appendix A - Tables 1 and 2 are a guide for types of measures that the Commission considers necessary for success on the All-payer Model requirements. In addition to high level goals that the applicants are pursuing, specific program-specific measures should be proposed by applicants. Applicants should provide the evidence basis for their approach.

4. Return on Investment

This section should describe specifically how the proposed program or intervention will move toward meeting the goals and requirements of the new All-Payer Model in Maryland. The expected hospital ROI for Rate Years 2017, 2018, and 2019 must be quantified (see Appendix A -Table 3 for an example and a blank template). Plans for utilizing the ROI retained by the hospital or partnership must also be specified and by when. In addition to the ROI for the participating hospitals, the HSCRC expects that a portion of the ROI accrue to payers. Applicants are expected to show how the ROI will be apportioned between the hospital(s), and payers, and how the payer portions will be applied (global budget reduction, etc.).

If the model or intervention is expected to reduce the total cost of care beyond the hospital, please quantify expected savings.

5. Scalability and Sustainability

This section should detail how the intervention/program is sustainable without additional rate increases in future years (beyond the ongoing amount associated with this competitive award). Plans for funding an expansion of the program/intervention if it proves successful should also be described. The partners should demonstrate a commitment to sharing resources and addressing alignment of payment models on an ongoing basis.

6. Participating Partners and Decision-Making Process

This section should include a list of the participating entities and a description of a shared decision making process that incorporates the perspectives of all partners. If a formalized governance structure will be used, it should be described in this section. This section should describe the roles and responsibilities for partnering organizations and the proposed funding for each.

7. Implementation Work Plan (no page limit to this non-narrative section, must use a project management software such as Microsoft Project™ or other equivalent program)

This section should clearly describe how different initiatives will move from a planning to implementation phase, including when the intervention(s) will begin.

8. Budget and Expenditures

This section should include a line item budget, using the template in Appendix D.

9. Budget and Expenditures Narrative (no more than 3 pages)

This section should include a brief narrative justifying the expenses. Funds should be used for implementation activities. If the proposal includes multiple interventions,

please show the budget for each intervention separately. Funds should be used for implementation activities. Examples of ineligible expenses are described in Appendix B.

Funds awarded are intended to leverage or build upon transformation plans or existing investments made for specific programs designed to meet the State's goals and requirements of the All-Payer Model agreement with CMMI, and improve population health.

This section shall include the percentage of the total investment of the program, model, or intervention is covered by the award, and the source of other funding to support the program, model, or intervention.

Total dollars awarded to a hospital acting as a single entity are capped at 0.5% of the hospital's FY 2015 net patient revenue plus markup. Total combined awards to a hospital through single entity applications, regional partnership applications, and multiple hospital applications are capped at 0.75% of the individual hospital's FY 2015 net patient revenue plus markup.

Investments included in the budget should have the potential to impact population health within the communities that each hospital, regional partnership, or collaboration serves. Investments included in the budget are expected to be data driven and able to be evaluated using measurable outcomes.

10. Summary of Proposal (2-3 Pages)

Applicants are required to summarize their proposal in a standard format. See Appendix C for the required summary format table. Complete one summary table delineating differences for each intervention in each category, if applicable

Selection Criteria

Applications will be reviewed and awarded funding based on the following criteria:

- 1) Appropriateness of the Target Population in terms of the potential to positively impact key outcome measures
- 2) Whether the program, model, or intervention is well-conceived, evidence-based and appropriately proposes to use infrastructure and workforce in an efficient and effective manner to improve care coordination, physician alignment, and health outcomes of the target population.
- 3) Consistency with All-Payer Requirements: Support the purpose of All-Payer Model. Positive results on the metrics in Appendix A would be seen as supporting the All-Payer Model.

- 4) Consistency with the participating hospital(s) strategic transformation plans submitted to the HSCRC on December 1, 2015 and consistency with other investments, including prior GBR infrastructure investments.
- 5) Results and Efficacy of Investment(s) to date.
- 6) Whether investments being proposed complement rather than duplicate state and regional resources
- 7) The extent to which the program, model, or intervention innovatively uses health information technology (telehealth, electronic health records, health information exchange) to improve care, create efficiency in care delivery, and reduce costs. The extent to which the program, model, or intervention supports alignment and the use of information across hospitals, physicians, post-acute care providers, and other community based providers with the goal of improving the delivery of care in a manner that achieves the core outcome measures outlined in Appendix A.
- 8) Patient-Centered: The extent to which the proposed interventions support patient-centered care delivery, meaning they demonstrate how the care coordination efforts flow among different providers for high risk patients using different hospitals and how the structures and efforts will have tailored technologies and methods to address patient and family preferences and engagement in their care. The extent to which consumer perspectives, engagement, communication, and outreach, are included in models.
- 9) The feasibility for a reasonable ROI in Fiscal Years 2017, 2018, and 2019 that allows for sustainability over time. The apportionment of ROI to payers. The potential to reduce the total cost of care including both hospital-based and nonhospital-based health care costs.
- 10) Implementation Plan: Level of detail and feasibility of implementation plans
- 11) Budget: The reasonableness and adequacy of the proposed budget. A clear description of how awarded funds will be dispersed to organizations and providers included in the application consistent with existing law.

Appendix A

Table 1. Core Outcome Measures

Measure	Definition	Source	Population(s) expected
Total hospital cost per capita	Hospital charges per person	HSCRC Casemix Data	All population for covered zips, high utilization set, target population if different, each by race/ethnicity
Total hospital admits per capita	Admits per thousand	HSCRC Casemix Data	All population for covered zips, high utilization set, target population if different, each by race/ethnicity
Total health care cost per person	Aggregate payments/person	HSCRC Total Cost Report	All population for covered zips, high utilization set, target population if different, , each by race/ethnicity
ED visits per capita	Encounters per thousand	HSCRC Casemix Data	All population for covered zips, high utilization set, target population if different, , each by race/ethnicity
Readmissions	All Cause 30-day Readmits (see HSCRC specs)	CRISP	High utilization set, target population if different, each by race/ethnicity
Potentially avoidable utilization	(see HSCRC specifications)	PAU Patient Level Reports	High utilization set, target population if different, each by race/ethnicity
Patient experience	% rating 9 or 10	HCAPHS	High utilization set, target population if different, each by race/ethnicity

Table 2. Core Process Measures

Measure	Definition	Source	Population(s) expected
Use of Encounter Notification Alerts	% of inpatient discharges that result in an Encounter Notification System alert going to a physician	CRISP	All population for covered zip, high utilization set, target population if different
Completion of health risk assessments	% High utilizers with <u>completed</u> Health Risk Assessments	Hospital, Partnership, Collaboration	High utilization set, target population if different
Established longitudinal care plan	% of High Utilizers Patients with completed care	Hospital, Partnership, Collaboration	High utilization set, target population if different
Shared Care Profile	% of patients with care plans with data shared through HIE in Care Profile	CRISP	High utilization set, target population if different
Portion of target pop. with contact from assigned care manager	% of High Utilizers Patients with contact with an assigned care manager	Hospital, Partnership, Collaboration	High utilization set, target population if different

Table 3. Core Return on Investment Measures

ROI = G (variable savings) ÷ D (annual intervention)

Proposed Savings of 15%

ROI should be greater than 1 at steady state operations (and get there early)

Illustration	High Utilizers ≥ 3 IP Admits	High Cost Top 10%
A. Number of Patients	40,601	136,601
B. Number of Medicare and Dual Eligible	27,000	79,000
C. Annual Intervention Cost/Patient	\$3,500	\$3,500
D. Annual Intervention Cost (B X C)	\$95M	\$277M
E. Annual Charges (Baseline)	\$1.9B	\$3.8B
F. Annual Gross Savings (15% X E)	\$280M	\$570M
G. Variable Savings (F X 50%)	\$140M	\$285M
H. Annual Net Savings (G-D)	\$45M	\$8M

Template to complete:

$ROI = G \text{ (variable savings)} \div D \text{ (annual intervention)}$

ROI should be greater than 1 at steady state operations (and get there early)

Hospital/RP Name:	Target Population
A. Number of Patients	
B. Number of Medicare and Dual Eligible	
C. Annual Intervention Cost/Patient	
D. Annual Intervention Cost (B x C)	
E. Annual Charges (Baseline)	
F. Annual Gross Savings (XX% x E)	
G. Variable Savings (F x 50%)	
H. Annual Net Savings (G-D)	

XX% is proposed savings from the proposed strategy(s)

Appendix B

Examples of expenses not covered include:

- Electronic health records or patient hotlines or portals that are used for care delivery and communication unless specifically implementing systems or modules for care coordination activities (e.g., electronic health record module for care manager to record activities or patient portal for contacting care manager).
- Most billable services (this does not include CCM payments). This means that expenses could be used to enable physicians to access CCM payments.
- Investments to improve coding or documentation, including upgrades to systems to be complaint with regulatory changes such as ICD-10.
- All retrospective and concurrent utilization review.
- Fraud prevention activities.
- CRISP participation fees other than specific projects not otherwise available to all CRISP users.
- Any expenses for physicians that do not clearly increase access to primary care or other healthcare services (i.e., expenses for acquiring existing physicians that does not result in any change in access but simply results in the existing physicians being owned by the hospital).
- Any expenses that are primarily for marketing purposes.
- Accreditation fees.
- Financial rewards to providers (e.g., pay-for-performance incentives). Programs however may use ROI for provider gain sharing and pay-for-performance incentives that are consistent with legal requirements.
- All other expenses that do not fall under care coordination and population health.

Appendix C Proposal Summary

Reviewers will use appendix C as a reference guide. As such, the applicants should provide short summaries with the most relevant points. Reviewers will rely on the more detailed Project Narrative for a more complete understanding of the proposal.

Hospital/Applicant:	
Date of Submission:	
Health System Affiliation:	
Number of Interventions:	
Total Budget Request (\$):	

Complete the summary table delineating differences by intervention for each category, if applicable.

Target Patient Population (Response limited to 300 words)
Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs (Response limited to 300 words)
Measurement and Outcomes Goals (Response limited to 300 words)

Return on Investment. Total Cost of Care Savings. (Response limited to 300 words)
Scalability and Sustainability Plan (Response limited to 300 words)
Participating Partners and Decision-making Process. Include amount allocated to each partner. (Response limited to 300 words)

Implementation Plan (Response limited to 300 words)
Budget and Expenditures: Include budget for each intervention. (Response limited to 300 words)

Appendix D Budget Template and Narrative

Hospital/Applicant:	
Number of Interventions:	
Total Budget Request (\$):	

Complete the budget table below, listing each type of budget line item, narrative summary description for each, and amount of expenses estimated.

Workforce/Type of Staff	Description	Amount
IT/Technologies	Description	Amount

Other implementation Activities	Description	Amount
Other Indirect costs	Description	Amount
Total Expenses/investments		

Appendix D

Summary of Support for Care Coordination Investment

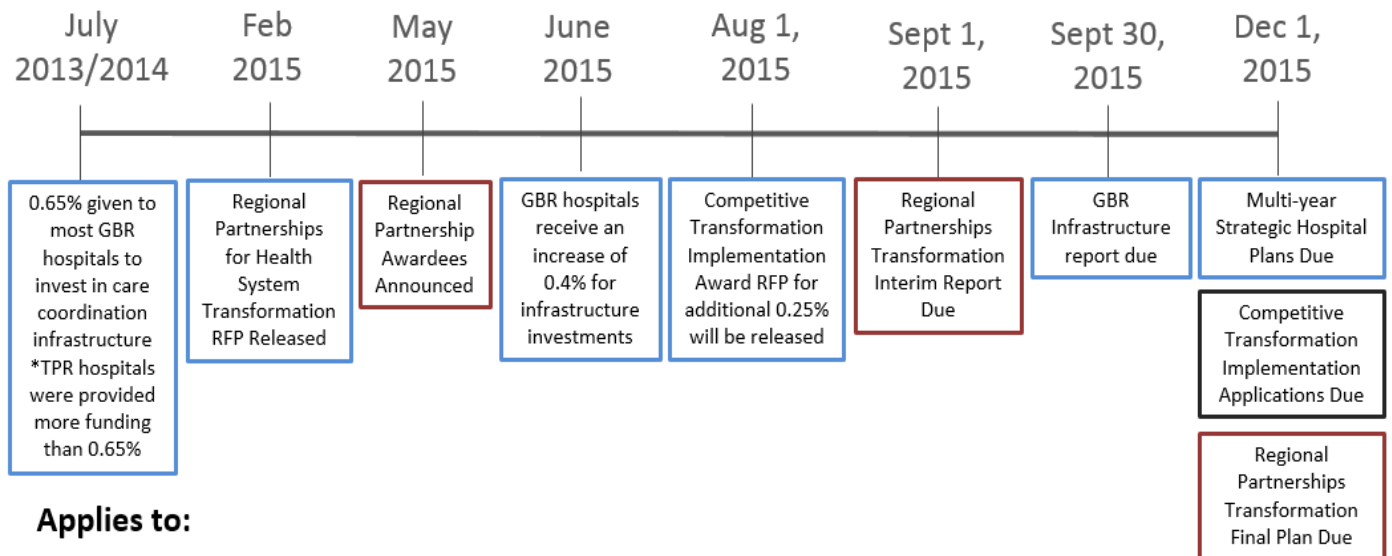
In Fiscal Years 2014 and 2015, the Commission, recognizing the need for seed funding to invest in best practices to improve care coordination activities, increased most GBR hospital's rates by a total of 0.65%, with the intent of it being used to invest in infrastructure that promotes the improvement of care delivery and reductions of potentially avoidable utilization. This funding was approved by the Commission to support the transformation with the expectation that the real return on investment will occur if projects are focused and well executed. TPR hospitals have been provided even higher levels of funding on a proportional basis. On September 30, 2015, all hospitals are required to submit a GBR Investment Report to HSCRC on the amounts and types of investments they have made and will make to improve population health, and how effective these investments are in reducing potentially avoidable utilization and improving population health.

In accordance with the provisions of the State Budget Reconciliation and Financing Act of 2014 (BRFA), earlier this year, the Commission increased rates (in FY 2015) effective May 1, 2015 to provide up to \$15 million for the purpose of funding the planning of regional partnerships throughout the State; and statewide infrastructure to support care management, coordination, and planning. In preparation for this funding, in February 2015, DHMH and HSCRC released an RFP to all hospitals offering funding to support the planning and development of *Regional Partnerships for Health System Transformation*. A portion of the BRFA funding (\$2.5 million) was awarded to hospitals who applied for the funding to support regional planning and development initiatives with key community partners. A multi-stakeholder review committee selected 8 of 11 proposals; funding ranged from \$200,000 to \$400,000. Those grantees are required to submit a final Regional Transformation Plan to DHMH and HSCRC on December 7, 2015.

During its June 2015 public meeting, the Commission approved additional increases to the global budgets of GBR hospitals for FY 2016 to continue successful investments in infrastructure. All global budgets of GBR hospitals will receive an increase of 0.4% for infrastructure investments. Separately, an additional 0.25% in competitive transformation implementation awards will be available to hospitals, working in collaboration with other hospitals, physicians, post-acute providers and other community based providers. Hospitals interested in applying will be required to submit proposals describing how they will use these additional funds for implementation of developed strategies to improve care coordination and population health. The Commission is releasing a Request for Proposals (RFP) and proposals will be due on December 7, 2015.

The Commission also approved a recommendation that will require all hospitals to submit multi-year strategic plans for improving care coordination, chronic care, and provider alignment. These plans will be due on December 7, 2015. The strategic plan should draw from the other required reports and demonstrate how strategies are aligned. All hospitals will be required to submit their own strategic plan; however, in areas where hospitals are working with one another through a Regional Partnership or other collaborations, they should reference their Regional Partnership Transformation Plan.

Timeline for RFPs and Reports



Applies to:

- Hospitals
- Regional Partnership Grantees
- Hospitals applying for Competitive Transformation Implementation RFP

Summary of HSCRC Required Reports:

Submission	Associated Funding	Report Due Date	Requirements/ Scope	Who
Interim Regional Transformation Report from Regional Partnerships	\$2.5 million (BRFA funding)	September 1, 2015	Interim Regional Transformation Plan Template (draft shared with grantees)	Regional Partnership Grantees
Global Budget Infrastructure Report	0.65% given to most GBR hospitals in July 2013/2014 *TPR hospitals were provided additional funding	September 30, 2015	GBR Infrastructure Report Template available on HSCRC website	All Hospitals
	0.4% increases approved for FY2016 for all GBR hospitals			

Final Regional Transformation Report from Regional Partnerships	\$2.5 million (BRFA funding)	December 7, 2015	Regional Transformation Plan Template (draft shared with grantees)	Regional Partnership Grantees *Partnering hospitals will collaborate on one final report
Strategic Hospital Transformation Plan for Improving Care	N/A	December 7, 2015	Similar template as Regional Transformation Plan only broader and more comprehensive in scope *Template forthcoming	All Hospitals *Plans should refer to and align with GBR Infrastructure Report, Regional Partnership Plan (if applicable), Community Benefit Report and Community Health Needs Assessments
Applications/Proposals for Competitive Transformation Implementation Awards	0.25% (approx. \$40 million)	December 7, 2015	RFP will be posted in August 2015. *Applications should draw from multi-year strategic hospital plan; must demonstrate how investments build on one another	All Hospitals are Eligible to Apply *Collaboration among hospitals in a single application is encouraged and collaboration with physicians and other providers is required. RFP will provide more details when released.

Other Required Reports:

Submission	Associated Funding	Report Due Date	Requirements/Scope	Who
Community Benefit Report	N/A	December 15, 2015	Template available on the HSCRC website	All Hospitals
Community Health Needs Assessment	N/A	Hospitals on 1-3 year cycle	Hospitals should follow federal CHNA requirements	All Hospitals

Technical Assistance Available to All Hospitals

In an effort to support the Regional Partnership Grantees through the process of establishing their plans for regional partnerships, the State, in collaboration with the Chesapeake Regional Information System for our Patients (CRISP), has assembled technical resources and consultants with broad experience and expertise in similar initiatives around the country. A portion of the statewide infrastructure funding is being used to provide this technical assistance support to the planning grantees and all hospitals and their partners throughout the State as they work their way through essential delivery system transformation. While planning grantees may avail themselves of one-on-one consultation (up to 60 hours) all hospitals and their partners will be invited to participate in a series of bi-monthly, topic-specific webinars and an interactive Learning Collaborative on specific topics of interest that will be designed to assist hospitals and their partners as they endeavor to improve their care coordination with the goal of real delivery system reform. Specific webinar topics will be sent closer to the meeting date; your input into the content of these events is encouraged. Please refer to the DHMH website for an updated list of webinar topics and resource material:

<http://pophealth.dhmh.maryland.gov/transformation/SitePages/Home.aspx>

A schedule of these events and opportunities are as follows:

- Webinar: Consumer Education and Outreach: September 10, 9-10am EST
- Webinar: Behavioral Health Integration Models: September 24, 9-10am EST
- Learning Collaborative: October 1, 9-10am EST
- Webinar: Topic TBD: October 8, 9-10am EST
- Webinar: Topic TBD: October 22, 9-10am EST
- Webinar: Topic TBD: November 12, 9-10am EST